STUDY PROJECT

A ROLE FOR THE ARMY MEDICAL SPECIALIST CORPS IN NATION ASSISTANCE

BY

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Regional crises or conflicts are the predominant threat to U.S. national security in the future. Peacetime engagement as an emerging U.S. national policy is a coordinated effort of political, economic, and military assistance to promote stability throughout the world. Military medical efforts can be a cost effective strategy to achieve this goal. This study promotes a proactive role for the Army Medical Specialist Corps in nation assistance. Army Medical Specialist Corps specialties have been involved in ad hoc nation assistance activities since the 1940s. An historical review examines specific capabilities and contributions made by each of the specialties. The Army Medical Specialist Corps can make a difference to host nation medical infrastructure development through nutritional and physical rehabilitation support, general preventive medicine, as well as the medical education and training. Future Army Medical Specialist Corps nation assistance activities, in other than an ad hoc fashion, will require development and promotion of specified concepts, policies and programs regarding an expanded and proactive role.

USAWC MILITARY STUDIES PROGRAM PAPER

A ROLE FOR THE ARMY MEDICAL SPECIALIST CORPS IN NATION ASSISTANCE

AN INDIVIDUAL STUDY PROJECT

by

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INTRODUCTION

With the collapse of the Soviet Union and the associated U.S.-Soviet hegemony that dominated world affairs, many nations are looking at new and different opportunities and challenges that face them in the 1990s and beyond. Similarly, the U.S. seeks to insure, in spite of these changes and consistent with its national values, that national security interests and objectives continue unabated in the nineties.

Nation assistance, conducted by the U.S., can provide one conduit to foster regional stability, deter conflict and protect U.S. national interests. As nations pursue their individual national objectives through economic, political and other means, the U.S. can promote self-development by encouraging and using U.S. resources and assistance.[1]

U.S. National Security Strategy seeks a stable and secure world where political and economic freedom, human rights and democratic institutions can flourish. The strategy includes:

- global and regional stability,
- worldwide democratic political systems,
- open international trading and economic systems, and
- assure global faith in America that it will lead a collective response to world crises.[2]

Continued political and economic instabilities of nations in turmoil pose a threat to U.S. national interests. An appropriate response, viewed by many, is to develop programs that attack the roots of the instability, i.e., poverty, debt, ignorance, and inadequate and disproportionate economic development.[3]

U.S. military aid, as in nation assistance, is one means to counterbalance the threat of instability in developing countries. The proactive application of this kind of nation assistance can sometimes be a cost-effective strategy. The actual cost of resources expended to help developing nations create their own growth and stability, can be relatively small on the grand scale, when compared to the human toll, economic costs, and regional instability that could occur once internal turmoil and conflict develop.

The current strategic environment suggests that nation assistance is one means to shape the future. For the Army, nation assistance in its truest form requires a paradigm change. This paper promotes a proactive role for the Army Medical Specialist Corps (AMSC), within military medical nation assistance areas, to help achieve national interests. The AMSC can be a key part of this effort.

Historically, the AMSC has provided nation assistance activities to many countries such as Korea, Vietnam, Philippines, Japan, Germany, El Salvador, and Honduras. This experience establishes a capability and commitment. These activities, however, were on an ad hoc basis as the AMSC traditional role was viewed as centered in Army Medical Treatment Facilities. Now is the time for the AMSC to make a paradigm shift, break from traditions and expectations and take a proactive nation assistance role.

THE ARMY FOCUSES ON NATION ASSISTANCE

Peacetime engagement is emerging as a significant part of U.S. national policy. President Bush in August 1990, outlined this new national security strategy in his Aspen Institute address. Peacetime engagement refers to the U.S. remaining actively involved in supporting stability and security in this post cold war.[4]

When Secretary of Defense Dick Cheney testified before the House Appropriations Defense Subcommittee in February 1991, he identified peacetime engagement, as a means in low intensity conflicts, to promote stability in the third world. He also defined peacetime engagement as a coordinated effort of political, economic, and military actions directed to reverse local violence and to promote nation assistance.[5]

By definition, nation assistance includes all cooperative actions taken by U.S. government agencies in concert with the host nation's government that promote development and growth of that nation's institutions. Typically, host nation agencies involved can include the military, ministry of public works, public education and health agencies.

A Peacetime Engagement Conference held in July 1991, attended by representatives of the Department of State, Department of Defense (DOD) and individual branches of the Armed services addressed concepts, programs and definitions concerning peacetime engagement. Though not totally conclusive, a concept did emerge from the conference that portrayed peacetime engagement as a manifestation of forward presence.[6]

As the Army directs itself to support this concept, doctrine must be rewritten addressing it's application across the full spectrum of military operations. Army planners

should focus on stability and nation assistance development, specifically with long range planning emphasizing nation assistance as an important part of peacetime engagement.[7]

CURRENT ARMY DOCTRINE

As defined in Army Field Manual (FM) 5-114, Engineer Operations Short of War, nation assistance is:

> political, economic, informational, and military cooperation between the U.S. and the government of another nation, with the objective of promoting internal development and the growth of sustainable institutions within that nation. This assistance corrects conditions that cause human suffering and improves the quality of life of the nation's people. Nation assistance is conducted to promote stability within the world, as well as for humanitarian reasons.[8]

Army roles and missions support military strategy. Relevant doctrine is being developed to match the changing global condition. Recently revised Army FM 100-5, Operations, discusses peacetime activities that include nation assistance. In chapter 5, "Operations Short of War," peacetime activities are defined as, ". . . those that support the Commander in Chief's (CINC) forward presence operations and the U.S. Ambassador country plan with interagency efforts."[9]

The conceptual framework of peacetime activity or engagement reflects a proactive Army dimension in support of forward presence. The Army has the capabilities to support these activities and assist other nations to build and develop strong infrastructures. Nation assistance, however, is not a new mission for the Army. U.S. military history is replete with an abundance of activities done under the aegis of what we now call nation assistance.

Nation Assistance in a Low Intensity Conflict (LIC) Environment

Army FM 100-20, Military Operations in Low Intensity Conflict, defines LIC as, ". . . political-military confrontation between contending states and groups rated below conventional war and above the routine peaceful competition among states." LIC can result when a political, social or economic vacuum occurs within a country resulting in internal conflicts.[10]

Within the complex world of regional politics, the U.S. seeks to stabilize and defuse pockets of conflict before they can escalate and mature into true regional conflicts with global security implications. U.S. policy recognizes that in LIC, indirect rather than direct applications of U.S. military power, are usually the most appropriate and cost-effective ways to achieve goals.[11]

At the invitation of a host nation, operations undertaken by U.S. military forces in a LIC environment include: civil-military operations, humanitarian, and civic assistance operations. All these operations can include applications of military medicine in some fashion which may be the least controversial and most cost-effective means of using military forces in direct support of nation development. Military medicine is considered a proactive force on the leading edge of supporting military LIC strategy.[12]

U.S. military health assistance activities are available to address many of the adverse medical conditions often seen in developing nations. Symptoms of these conditions are often manifested by high infant and child mortality, parasitic diseases, malnutrition, dietary deficiencies, untreated chronic conditions such as diabetes, hypertension, inadequate immunization programs and other medical problems. Added to these problems are domestic

issues of poor sanitation, poverty, illiteracy, scarcity of health professionals, and inadequate food distribution programs.

U.S. military health assistance activities are special and useful adjuncts when coordinated with a complete plan for the nation and committed to long term goals. It has been shown that medical teams can enter problem areas and remove important causes of discontent even before the situation degenerates into open conflict.[13]

These military medical services may include:

- public health and preventive medicine-hygiene, immunization, and training in nutrition, safety, child care, home remedies, and paramedical skills,

- diagnosis and treatment of trauma and disease,

- provision of medical supplies, prostheses, and eye glasses,

- provision of continuing education for local civilian doctors, nurses and technician specialists, and

-consultation with local medical personnel."[14]

The Army Medical Department (AMEDD) in Nation Assistance

The evolving role of the AMEDD in nation assistance really began as its medical personnel worked side-by-side with regular Army forces to handle domestic disaster assistance missions. Use of Army medical assets outside the U.S. did not occur until the early twentieth century.[15]

U.S. involvement and military action in the 1898 Spanish American War placed the Army into Cuba, Puerto Rico and the Philippines. Army medical personnel became actively involved with efforts to control contagious diseases and prevent and control epidemics.[16]

After World War (WW) I, medical missions became part of larger comprehensive U.S. relief efforts to reduce starvation and disease among European noncombatants. These missions implied a decision by American leaders to employ humanitarian relief to encourage governments and ideologies compatible with its own.[17] During the interwar years of 1918-1938, U.S. Army medical personnel participated in small foreign assistance programs. After WWII, it became common place for the Army to provide humanitarian aid to victims of natural disasters.[18]

As the U.S. engaged in the cold war against communism, the employment of American medicine became a means to show a superior system to build the strength of the free world. In 1961 Major General Leonard D. Heaton, Surgeon General of the Army, advocated a policy, ". . . of employing American medicine . . . to improve our relations with the free nations of the world, in particular the 'underdeveloped' countries." General Heaton felt this policy would help remove the sources of totalitarianism and make the U.S. more secure.[19] Clearly by the 1960s, the U.S. was using the Army and their medical resources to support U.S. objectives and interests in other nations.

Army Medical Specialist Corps in Nation Assistance

The AMSC is currently composed of four separate professionals and specialty skill identifiers (SSI): occupational therapists (65A), physical therapists (65B), dietitians (65C) and

physician assistants (65D). Although occupational therapists, physical therapists and dietitians have been commissioned officers since the Corps founding in 1947, physician assistants were only commissioned into the AMSC beginning in February 1992. This action resulted from the December 5, 1991 DOD appropriation bill authorizing legislation to integrate and commission, Army warrant officer physician assistants into the AMSC.[20]

In parallel with AMEDD involvement in nation assistance, the AMSC has also been similarly engaged, especially from the 1960s onward. Dietitians, occupational therapists and physical therapists have been involved in special assignments outside their traditional hospital roles in support of medical humanitarian and nation assistance missions abroad. Before the Vietnam era and formalization of civic action programs, most medical assistance provided by the AMSC was limited to selected specialties for a designated event.

The newest AMSC specialty, physician assistants, has a limited historical perspective with nation assistance involvement since the specialty was not established in the Army until 1973. One might imagine their experiences and involvement would be similar to those seen previously by physicians in the Medical Corps because of the similarity of functions performed.

By searching the Corps historical annals one can find out the details and scope of their involvement in nation assistance. The true roots of AMSC contributions abroad began as early as 1917 and went into high gear during WWII, although most of the efforts were devoted to providing direct care to U.S. military forces. The starting point for the purposes of this historical review begins closely to the AMSC formation year of 1947.[21]

1946-1955

In February 1946 a Philippine Amputation and Prosthetic Unit, appointed by direction of the Secretary of War, established an amputation center and prosthesis shop in the Philippines. Three AMSC officers, one physical therapist and two occupational, therapists were assigned to train the Filipinos in prosthetics construction and the treatment of amputees.

The Chief Surgeon of U.S. Army Europe, sent a physical therapist to Athens to help establish a physical therapy clinic in Athens. This was necesary to care for one hundred polio patients during the 1949 Greek polio epidemic.

A physical therapist was assigned as early as the autumn of 1951 to help Korean medical personnel set up rehabilitation programs for amputees in the Republic of Korea hospitals. A year later two additional physical therapists, were temporarily assigned to the Armed Forces Assistance to Korea Program. This was the first sustained and concerted U.S. military civic action program because the emphasis was on schools, hospitals, civic buildings and improving public health and transportation facilities.[22]

In 1959 both a dietitian and physical therapist were assigned to the U.S. Army Mission, Peru to prepare Peruvian personnel to operate a newly constructed hospital in Lima. The dietitian conducted classes and supervised the training of local food service personnel. The physical therapist instructed Peruvian students in the operation of their Physical Medicine Service.

In 1962, a dietitian served in Jordan as a member of the Interdepartmental Committee on Nutrition for National Defense (ICNND) which included scientists, teachers, and consultants. At the request of the Jordan Ministry of Foreign Affairs, through the American

Embassy, the team was asked to conduct a nutrition survey in the Hashemite Kingdom of Jordan.

The main objective of the Jordan study was to characterize the nutritional status of the population, appraise the availability of food sources, assess dietary patterns, assess technology and production of food, and review hospital and institutional feeding. Another goal was to provide training and experience for the responsible ministries concerned with nutrition.[23]

One year later in 1963, another dietitian served as a member of an ICNND team that conducted a similar nutrition survey in Venezuela. The American team accompanied a Venezuelan team and surveyed six major geographical areas.

In 1964 a dietitian accompanied a medical military training group to Bogota, Columbia to help establish a Food Service Division in the military hospital. A training program for the Columbia workers was also incorporated.

The unique individual experiences and opportunities, gained in the sixties, were not only rewarding to these individuals but would sow seeds for future AMSC opportunities on a grander scale and as part of military medical plans.

1965-1975

Vietnam was the most galvanizing event during this period. Under various names, host nation programs had a long term goal of molding a cohesive and self-governing nation. The goals also contained civil oriented actions such as the training of teachers, building

schools, developing civil administrators for villages, and improving the health and living conditions.[24]

Military medical efforts to build a medical infrastructure in Vietnam began in 1965 when the Secretary of Defense directed medical services to prepare a program to assist the civilian effort achieve an independent self-sustaining health service. This health service effort was a joint activity between the State Department and the U.S. Military Assistance Command, Vietnam and became known as the Military Provincial Health Assistance Program (MILHAP) and the Medical Civic Action Program (MEDCAP).[25]

When Army medical units were first sent in to Vietnam, AMSC officers were not included; however it soon became obvious that dietitians and physical therapists would be needed in strength. In April 1966, the two dietitians and one physical therapist arrived and in 1967, AMSC officer authorizations were formally given to the medical organizations and the build up continued.[26]

Major Patricia Accountius was the first dietitian to serve in Vietnam. She was initially assigned to the 3rd Field Hospital but was soon transferred to the 68th Medical Group to coordinate area hospital food service functions. As the scope of her work broadened she was assigned to the Medical Directorate in the 44th Medical Brigade as the first dietetic consultant to the Surgeon, USARV.

Besides her responsibilities to establish food service equipment and supply requirements for the U.S. Army hospital units, she wrote the first 28-day cycle menu for American, Australian and Korean soldiers. She was also involved with justifying supplementation for the nutritionally inadequate Vietnamese Army rations; and evaluating a

dysentery outbreak at a local civilian hospital where she learned that unsanitary kitchen habits were the culprits.[27]

Her responsibilities at the group and brigade level prohibited any personal involvement in any MEDCAP missions. However, she observed that while there was no formal program for involvement in MEDCAP "the level of interface was left up to the hospital's discretion."[28]

Army dietitians assigned to Vietnam from 1967 through February 1973 typically served at field hospitals, at medical groups and at medical brigade level assignments. Although no dietitians personally participated in formal MEDCAP missions, many provided staff assistance in various nutritional activities directly to the Vietnamese people. Such activities included: completing a nutritional analysis of the Army of the Republic of Vietnam (ARVN) menus by evaluating the food supply and nutritional content of the local foods at the request of the U.S. ambassador as part of the Vietnamization program, documenting the nutritional adequacy of food fed to the North Vietnamese prisoners in ARVN prisons, and evaluating nutritional and sanitation capabilities of civilian hospital kitchens.[29]

Beginning in 1966 physical therapists were assigned to field and evacuation hospitals.[30] Captain Ruth Dewton, although not formally assigned to a MEDCAP mission team, was interested in these missions and often voluntarily accompanied the team. Additionally, during her free time, Captain Dewton worked with the National Rehabilitation Hospital teaching and training the Vietnamese physical therapy technicians. Specific therapies included: work and war related injuries, amputees, polio patients, peripheral nerve

injuries, spinal cord injuries and assorted range of motion programs. She also participated in similar teaching programs at the Seventh Day Adventist Hospital.[31]

Other physical therapists had similar teaching experiences that included: helping with the rehabilitation programs being established at the ARVN hospitals, teaching physical therapy skills to Vietnamese nurses and technicians in Vietnamese military hospitals, evaluating and teaching prosthesis work for the amputee children at hospitals in Saigon, and consulting activities to the Vietnamese military and civilian hospitals.[32]

1975-1990

After Vietnam there was a conscious redirection of efforts away from U.S. involvement in limited war strategy. However, by the 1980s U.S. Southern Command (SOUTHCOM) found itself facing a low intensity threat in Latin American and realized that civic military action would be a necessary strategy and that medical assets were important.[33]

The SOUTHCOM command surgeon's staff developed The Regional Medical Strategy to support SOUTHCOM objectives. The strategy used medical initiatives along with military assets to help host governments develop plans and address their own health care needs, possibly preempting the lack of health care as an insurgent issue.[34] Specifically, El Salvador and Honduras became two target countries where medical assistance was used as part of the military strategy.

In August 1983 the Army's 41st Combat Support Hospital deployed to Palmerola, Honduras in support of training exercise AHUAS TARA II (Big Pine). The commander,

with concurrences of both SOUTHCOM and Health Services Command (HSC), initiated a medical assistance program similar to the Vietnam MEDCAP programs.
His MEDCAP objectives were to:[35]

1. establish a program to improve U.S. relations with the Honduran people and
2. assist the Honduran military medical system.

U.S. medical presence in Honduras was scaled back in the late 1980s when congressional funding became controversial. The MEDCAP program was renamed Medical Readiness Training Exercises (MEDRETES) and the National Guard and U.S. Army Reserve medical units were tasked to staff this functional exercise.[36]

Between September 1983 and May 1984 three Army dietitians deployed to Honduras. They often participated in MEDCAP type missions. One dietitian observed that improving Honduran sanitary conditions was the one area most needing attention as evidenced by the large number of local people seen with worms.[37] Another dietitian expanded the dietitians' role beyond managing hospital nutritional services for the U.S. troops and Honduran military patients. She provided special feeding and diabetic diet consultations to local hospitals and participated in MEDCAP missions recording heights and weights and performing arm circumference and triceps measurements to determine a nutritional assessment for the population.[38]

In October 1986, a dietitian in the U.S. Army-Baylor Program in Health Care Administration program, visited the Joint Task Force B-Medical Element (JTFB-MEDEL) and contributed to the MEDCAP program.[39] Fluent in Spanish, he served as a translator and observed medical activities in several areas. In particular the MEDEL Commander

needed dietetic information on sodium, clear and full liquid, pediatric and progressive diets for treatment of kwashiorkor. Additionally, this officer was asked to meet with the director of a large day care center to discuss the children's dietary needs.

A 1983 visit by the Assistant Secretary of Defense for Health Affairs and the Army Surgeon General's representative to El Salvador confirmed earlier reports that the lack of a field medical system directly related to high attrition rates among Salvador soldiers. In response to this visit, a Medical Mobile Training Team (MMTT) was organized and staffed.[40]

General successes of the MMTT included a reduction of mortality rate for soldiers from 45% to 5%, construction of a combat support hospital, work with the U.S. Agency for International Development to establish troop clinics throughout the country side, improved sanitation, reduction in malaria, dysentery and wound infections and the creation of a rehabilitation center to treat orthopedic casualties.[41]

In January 1986 the MMTT requested support for a dietitian, occupational therapist and physical therapist. The dietitian assigned volunteered for two back-to-back six-month temporary duties as no other Spanish speaking dietitians were available. Occupational therapists and physical therapists remained on the MMTT's into 1989.

The dietitian, fluent in Spanish, helped the Armed Forces of El Salvador as a trainer and advisor at both military hospitals teaching acceptable dietary and administrative practices to food service personnel. She was the also the dietetic consultant to the Commander of the host country medical team.[42]

Occupational therapists characterized their roles as trainers to the local occupational therapists. As a result of indiscriminate use of land mines by the Salvador guerrillas approximately 1600 individuals, both military and civilians, were waiting for assistance from rehabilitation facilities. Many of these patients had peripheral nerve injuries, head trauma and spinal cord injuries secondary to gunshot wounds. They lacked total rehabilitation care and many had developed severe complications such as joint contraction, atrophy and deformity as a result of late intervention.[43]

Observing the hundreds of young men who were literally hanging around the hospitals with poorly constructed prosthesis or waiting for prostheses, one occupational therapist, Captain Leonard Cancio, saw a need to build up and strengthen patients' upper extremities. When asked to review the idea of forming amputee soccer teams, he realized this could be used as an outstanding rehabilitation modality. He enthusiastically recommended team organization and became one of the first trainers. These teams were a runaway national success and even participated in championship matches held in the U.S. The formation of these soccer teams was just one example of the more unusual successes for the MMTT employing the occupational therapists and physical therapists to provide long term benefits for U.S. policy.

In El Salvador, physical therapists worked with both military and civilian staff in the hospitals. Eighty per cent of their role was hands on teaching. Specifically, the physical therapists trained and evaluated trauma and burn patients resulting from mortar and incendiary weapons, wounds and injuries from ballistic injuries, traumatic amputations and lower and upper extremity injuries from mines.[44]

Both occupational and physical therapists assisted the Center of Education and Rehabilitation of the Armed Forces in El Salvador in establishing programs to make prosthetic devices and set up rehabilitation facilities. The basic program was designed to teach and train the Salvadorans in specific skills making them self-sufficient in rehabilitation capability.[45]

In June 1989 in the Russian Republic of Baskyria, a catastrophic natural gas explosion engulfed two passenger trains leaving many civilians with severe burns. The severity and magnitude of the burn injuries overwhelmed Russian medical capabilities and the U.S. Army Institute of Surgical Research at Fort Sam Houston, Texas was asked to send in a special burn team. After arrival, the team assessed the need for both occupational and physical therapy intervention. Lieutenant Colonel Rosendo Gutierrez, a physical therapist, joined the effort along with an enlisted Army occupational therapy technician.[46]

The physical therapist became involved with a combined treating and teaching role. Knowing participation time was short, he concentrated on teaching burn care rehabilitation skills to Soviet reconditioning specialists which were their closest equivalent specialty. Areas taught included deformity and contracture prevention as well as early mobilization and progression exercises for the patients.[47]

An unusual nation assistance opportunity, in August 1989, dropped in the lap of one occupational therapist assigned to Gorgas Army Community Hospital (GACH) in Panama. Captain Karoline Harvey frequently worked with a physician assistant assigned to Special Forces 7th Group. This individual saw a need for occupational therapy skills and arranged

for the occupational therapist to accompany a Special Forces team including two other physicians and two physician assistants.

This team spent six weeks in Peru and four weeks in Columbia traveling to outlying villages working with civilian and military counterparts. The occupational therapist taught orthopedic splinting and casting and worked with child physical disabilities in hospitals, while the physician assistants provided general medical care and teaching preventive and first aid skills.[48]

On December 24, 1989 HSC deployed two Army dietitians to GACH, Panama in support of Operation "Just Cause". They became involved with providing nutritional support for refugee camp operations, basically a humanitarian mission supporting a larger military objective.[49]

Emergency and refugee feeding were the primary challenges as the displaced persons camp fed up to 8,000 Panamanian people daily. Refugee feeding concerns included food consumption and meeting the nutritional needs of a high risk population. The dietitians established a baseline nutritional assessment for high risk group members. Appropriate and cost-effective meal plans using Panamanian food staples and emergency food plans were coordinated and established. Army dietitians attended meetings with the Panamanian Ministry of Foreign Affairs and the Ministry of Health to work out the problems of food procurement, distribution, and the distribution of nutrition information packets at the camp distribution points.[50] AMSC involvement with "Just Cause" provided valuable training for the Army dietitians when working with another nation's nutritional considerations and with non-U.S. government infrastructures.

In November 1990 World Vision, an International Christian relief and development agency, contacted Colonel Jane Sweeney, a researcher at Walter Reed Army Medical Center and a pediatric specialist-physical therapist, to voluntarily lead a long term physical therapy services project called ROSES (Romanian Orphan's Social and Educational Services). Colonel Sweeney recruited a team of civilian American physical therapists, active duty Army physical therapists, and a U.S. Army reserve physical therapist. The team traveled to Romania on their own time and administered baseline developmental testing for institutionalized Romanian children.[51]

They also led training sessions for Romanian physical therapists and doctors as the former dictator, Nicolae Ceausescu had disbanded all health professional associations and the state of medical training and education was in disarray. One of Colonel Sweeney's goals is to link the new Romanian physical therapy associations with the American Physical Therapy Association.[52]

Colonel Sweeney highlights the importance of this kind of work. "This program helps rebuild health care systems and provides humanitarian medical assistance to countries that have been in conflict or that are in need . . . this is an opportunity for Army health providers to work in a field environment without sophisticated equipment and library resources. It also gives experience interacting with people of different cultures and building international relationships that may be useful in future overseas assignments or deployments."[53]

TRENDS AND RECOMMENDATIONS

Military medicine has come a long way from its initial ventures. Credit should be given to those who have advocated military medicine as a crucial element in civil military operations. Culminating efforts are now seen in Army FM 8-42, Medical Operations in Low Intensity Conflict. Before this FM was published, limited medical doctrine existed for conducting medical operations much beyond the clinical environment.

Although FM 8-42 discusses medical activities in a LIC environment, these medical actions and programs support nation assistance roles by:

- assisting with the refinement or development of the military medical infrastructure,

- providing and maintaining the necessities of life for the general population through host nation civilian medical programs and,

- providing assistance to repair, improve, or establish basic services once hostilities have ceased. [4]

The capabilities contributed by the AMSC specialties include nutritional and rehabilitation support as well as general preventive medicine. AMSC officers have been involved in humanitarian, civic action, disaster, and medical mobile training teams, and medical unit exercises.

Dietitians have helped in refeeding healthy populations, worked with malnourished populations, planned for and provided special diets to the military and civilian casualties, advised host nation care providers on nutrition support for wounds, injuries and disease, assessed the nutritional status of general populations, and host nation military and civilians,

and recommended ways to achieve optimum nutritional levels with the local available foodstuff.

Occupational therapists have contributed to the rehabilitation of military and civilian casualties, treated upper extremity sprains, strains and fractures, fitted upper extremity prosthetics, helped in splinting training, screened and treated children with developmental delays, and instructed host nation personnel.

Physical therapists have instructed and supervised physical rehabilitation in many medical situations, especially minor and moderate orthopedic injuries and primary evaluation and treatment of musculoskeletal injuries, and burn care requirements.

Physician Assistants, the newest specialty in the AMSC, have a chance to further a Corps role in nation assistance with their skills to dispense emergency and primary medical care. This, along with their ability to train and teach medical assistants in developing nations portends a prime role in the future.

All of the specialties have been consultants to the host nation medical education systems in training and developing appropriate professional practices and protocols. The AMSC has met the challenges and taken opportunities to expand their professional skills in support of host nation support.

Recommendations

A continuing and expanded future role for the AMSC in nation assistance activities are clearly suggested. The old adage that you can and should shape your own future, because if you don't, someone else will is more than rhetoric. As the Army undergoes

significant transformations, it is now more important than ever for the AMSC to take charge of its own future or lose the opportunity. The AMSC can shape its own nation assistance role by constructing a formal nation assistance program and marketing it to the Army Surgeon General for approval and integration within AMEDD plans and programs for resourcing.

Within that program **five major areas** require emphasis:

1. Expanded Doctrine and Policy

As U.S. national security interests and strategy focus on nation assistance opportunities, the AMSC must formulate and articulate its own role. As several Corps within the AMEDD have been successful in experiences with nation assistance, the AMSC needs to dovetail its role and capabilities along with an overall AMEDD plan.

AMSC leadership needs to define its nation assistance concepts through doctrine and policy statements and incorporate into documents such as FM 8-42. The AMSC nation assistance strategy should define professional capabilities, potential resources and long term commitment goals and objectives.

The newly designated AMSC Division at the AMEDD Center School is the likely place for developing doctrine and policy concepts under guidance of the Office of the Chief, AMSC. It is a safe assumption to say that if AMSC officers are not involved at the concepts and doctrine stage they will not be considered during the application phase.

2. Planning and Coordination

Once AMSC policy and doctrine are formulated, it is imperative that AMSC leadership takes steps to articulate and present its interest, capabilities, and resources plan to other agencies involved in nation assistance to include the State Department, Major Commands, Joint Special Operation command channels and the medical commands for the unified CINCs.

The AMSC must **coordinate** and **network** relationships with individuals within the planning elements of these major functions securing advocates for AMSC specialties in nation assistance missions.

3. Professional Training and Education

The AMSC needs to develop and start special programs that provide regional military medical strategy assessments, language and culture information, and regional medical health assessments. These programs should be integrated at the AMEDD officer basic and advance courses as part of the AMSC track. Training of this nature should be included in the AMSC annual short course programs.

The AMSC needs to develop a cadre of language specialists. It is important the specific language skills be identified and a foreign language track established that would include attendance at the Defense Language Institutes.

Officers should attend national professional association conferences and participate in international health forums. Individuals who participate in nation assistance should be

encouraged to prepare and submit articles to their professional journals and military publications.

4. Lessons Learned

The AMSC needs to establish structured mechanisms to document its own nation assistance history. A designated position, in the Army historian office or at the Academy of Health Sciences, needs to be responsible for capturing the data and be accountable to the Office of the Chief, AMSC.

After action report formats should be standardized and individuals who are selected for nation assistance assignments should have ready access to material on previous lessons learned and receive instruction on information required for future reports.

AMSC and AMEDD nation assistance reports need to be distributed, as widely as possible, to other Corps members, civilian and military media. A specific forum needs to be developed and instituted for individuals to compare and share the experiences and lessons learned.

5. Change the Paradigm

Leaders facilitate paradigm changes. To participate in future nation assistance missions, the AMSC needs leaders to pursue and facilitate these changes. The AMSC should proactively request expanding missions for nation assistance, making nation assistance a secondary mission as opposed to a special assignment.

The time has come to recognize fully the valuable health care skills and abilities of the AMSC specialties in nation assistance as the U.S. Army marks the approach of the 21st century.

CONCLUSION

The strategic landscape has been significantly altered with the developments in the former Soviet Union and Europe. Without opposing superpower geopolitics, regional crises or conflicts will be the predominant military threats to U.S. national security interests. The challenge for the U.S. is to look beyond the horizon promoting strategies to further its goals of world political and economic freedoms, and the promotion of human rights and growing democratic institutions.

Nation assistance efforts as part of National Security Strategy can help to achieve national interests and objectives. National Military Strategy, current Joint Chiefs of Staff publications, and Army doctrines define nation assistance roles and provide guidance in which the U.S. can help host nations achieve economic, political and military stability.

The three keys to entering the 21st century are anticipation, innovation and excellence. The latter key, excellence, requires a paradigm change.[55] Future excellence and stability for the U.S. and the global world lie in developing an evolving co-dependency among nations in the development of economic, political and medical interdependence.

The AMSC has taken small but measurable and deliberate steps in proving a commitment to nation assistance. The Corps is ready to accept future opportunities, challenges and the responsibilities that come with nation assistance roles. The AMSC needs to now take the required steps to develop a proactive role for itself in the changing environment for the world, the Army and the Army Medical Department.

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